CASE REPORTS

PRIMARY CHRONIC INTUSSUSCEPTION IN AN ADULT

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CLINICAL HISTORY.—Mr. H—— H——, aged forty years, a carter by occupation was admitted to a medical ward of the Mater Hospital under the care of Dr. T. Kean. I was asked to see him because his symptoms were suggestive of chronic appendicitis. He had pain and tenderness in the right iliac fossa. He gave a history of a previous illness characterized by generalized swelling and pus in the urine.

No operation was performed on admission, and the symptoms became more severe. He then developed attacks of colic, accompanied by vomiting. He was constipated. He lost weight.

ON EXAMINATION.—He was a thin man with abdominal tenderness which varied in position, and which could be localized to the right side. He had an intermittent cystic swelling in the right hypochondriac region which varied in size from day to day.

INVESTIGATION.—He had albuminuria.

Cystoscopy.—Bladder and ureteric orifices were normal.

Right Pyelogram.—A normal but movable kidney.

Barium Meal.—Stomach and intestines were normal. A definite hold-up occurred in the hepatic flexure.

DIAGNOSIS.—A new growth of the hepatic flexure was suspected.

FIRST OPERATION, 31st OCTOBER, 1933.—The abdomen was opened through a right paramedian incision. A chronic intussusception of the ileo-cæcal region was discovered. The tumour came easily out of the wound, but attempts at reduction failed. Malignancy as an underlying cause could not be excluded, although it was considered improbable.

A junction was established between the ilium and the transverse colon. It was expected that this would relieve the more acute symptoms, and that resection would be possible later.

SECOND OPERATION, 21st NOVEMBER, 1933.—The patient had improved, but the colic returned four days before the second operation. The abdomen was reopened through the old incision. Omental adhesion had formed, and mobilization of the tumour was difficult. It was found that the apex of the intussusception had moved over towards the splenic flexure, and that the short circuit stoma was now obstructed. Right hemicolectomy was performed.

THE MACROSCOPIC APPEARANCE.—On examination of the specimen after removal, the ileo-cæcal valve appeared to form the apex. No gross disease of this region could be found. The part removed is at present in formaline, and the appendicular region has not yet been examined.

PROGRESS.—The patient is doing well after his recent operation.

COMMENT.—I believe that this is a case of chronic primary intussusception. There is a tendency to regard all cases of this disease as secondary conditions. For instance, the common acute intussusception of infants is said to be secondary to an inflammation of a Peyer's patch. I think that this idea is pure speculation, and I cannot see how an investigator could possibly collect material to prove the theory. Primary intussusceptions occur at death. I recall a large intussusception in the dissecting-room which was undoubtedly primary, and I have seen a similar condition at operations. On one occasion when examining the small intestine for associated injuries in a case of ruptured spleen, I noticed two small intussusceptions, one of which was retrograde. I reduced these, and they re-formed at once. It struck me forcibly that there is something in the contraction of normal bowel to explain this phenomena. The patient was under gas and oxygen. I have noticed that in cases of this disease in children it is possible to deliver the tumour before complete reduction. I think that this shows that the peritoneal attachments of the ascending colon are abnormal. The view that the condition is primary fits in very well with the common site of the disease. Why it occurs at the age of nine months has not been explained. It may be that at that age the variation between the diameter of the large and small bowel is at the highest point. Why it is more common in males is also unknown.

One other fact of interest is the question of protrusion of the apex at the anus. The textbooks mention this as a sign, and students are inclined to doubt that this occurs. I think that the textbooks were written in days when intussusceptions were neglected. I once operated on a case of five days' standing, and I was able to feel the apex per rectum.

The operation of ileo-transversostomy is neglected to some extent by works on operative surgery. Many surgeons I have met treat it with distrust. I have done this operation as a first stage for an operable growth of the ascending colon. Obstructing growths in this region are fortunately rare, and when found unexpectedly the surgeon is tempted to do this operation. I think that it is very dangerous under these conditions, unless it is combined with drainage of the bowel. I think that this operation without drainage in cases of acute obstruction is responsible for the distrust with which it is treated. In doing this operation I always make a large stoma in spite of the fluid contents at this point. I have seen contraction of the stoma at this point, and I think it possible that contraction is more liable to occur here than elsewhere. I think that the healing is interfered with by sepsis, and by the difference in thickness of the bowel walls.

A CASE OF FEMORAL EMBOLISM

By D. C. PORTER, M.B., *from the Royal Victoria Hospital, Belfast.*

THE patient, a female aged sixty-three years, was admitted to hospital on 19th February, 1933. She complained of shortness of breath on exertion, swelling of